Health Reform Commission – Executive Committee Meeting

Meeting Minutes, Tuesday, June 14, 2011
Department of Administration, Conference Room A

I. Call to Order:
   a. The meeting was called to order by Lt. Governor Roberts, who announced that though previous agendas had outlined a conversation about CON, the group has opted to bring some of the policy questions that needed discussion before this group today.
   b. Deb Faulkner – consultant to OHIC, and Jon Kingsdale - Wakely Consulting Group are here to present issues that this group must be aware of.

II. Presentation: Health Insurance Exchange Planning for Rhode Island
   a. Deb Faulkner – consultant to OHIC, presented on background and context.
      i. *What is an exchange?* A robust marketplace for all Rhode Islanders to identify health insurance options, purchase coverage, choose health insurance options, and enroll in health coverage.
      ii. Key deadlines in getting to 2014 in the exchange build:
         - June 2011: Legislation
         - September 2011: Apply for implementation funds
         - January 2013: Prove readiness to the federal government
         - July 2013: Enroll Rhode Islanders in coverage
      iii. Legislation is needed in order to have legal authority and governance to apply for the implementation funds. Question on legislative authority: If Rhode Island fails to pass legislation and doesn't create its own system, what will happen? Answer*:* Rhode Island could default to the Federal Exchange plan.
      iv. Major steps to get to the 2014 deadline:
         - March – September 2011: Develop a business plan
         - June 2011 – March 2012: Develop operational design and Request for Proposals
         - January – December 2012: Build Buy Integrate
      v. RI Starting Point: What are our strengths and what are our limitations?
         1. Size and scale: If everyone who is currently eligible and not enrolled, who are the legal residents under 65 who would be served by the exchange now, and in 2014? In 2014, the Affordable Care Act includes a Medicaid expansion, including everyone under 133% of the Federal Poverty Level (hereafter FPL).
            a. In Massachusetts, it appears they misestimated some of these numbers, so the question was raised as to how these numbers came about. Ms. Faulkner noted that this is an ACS survey, and it is clear that this is not a RI-specific survey of population needs. This is a maximum enrollment, assuming that those who do not have access to

affordable coverage now will switch over in 2014 through the exchange.

b. Affordable coverage is a graduated percentage of income. If a large employer has employees that access individual tax credits, then there is a penalty on the large employer to limit that from happening. There is a percentage based on the income scale of the workers that is the affordability threshold, and above that threshold there is a small percentage that have the option to switch to the exchange (most small groups will switch to the exchange - some to Medicaid, but most to the exchange).

c. The question was raised as to how other states with similar population size are anticipating the changes? The response came that though RI should look to similar sized states, it does become complicated when the political world does not give us a model to compare to, and for ideological reasons, they haven't moved forward. There are two or three that do fit the profile, and RI will need to take a look at those.

2. Rite Care Program: Expanded Rite Care coverage already covers 9,000 parents and 21,000 children over 133% FPL. Effective Rite Care procurement model shows what we have, what is working, and how we can build. RI also has specialized Medicaid Managed Care Organizations – a question is what roles will these plans play in the exchange? When one thinks about low income Rhode Islanders, even 133-200% FPL, the current thought is to consider what we have and build upon that.
3. Individual Insurance Market: When one compares the market now and what it will be post-2014, it is dramatically different. It will change to a competitive market with a risk management profile and considerations on how best to manage must be considered; RI needs to be prepared to serve a larger market.

    a. Alignment between the Medicaid program and the exchange: management, procurement models. One minimum essential benefit is compared to Medicaid benefits and the current commercial market. Regarding less benefits and more cost sharing, how do the essential benefits work with that, and will it change that? This state has a significant number of mandated benefits and only 30 of the 42 are in the essential benefit plan. Does the federal government pre-empt the state rules? In the exchange, if the benefit mandates exceed the essential benefits, you can have them, but the federal money will not pay for them, thus making RI on the hook to cover those state determined mandates. The state would have to assume the cost not only of the subsidies, but also the cost to

unsubsidized individuals in terms of the extra premiums because then the state is making it "not affordable." Affordability is defined in the statute on a graduated scale of income. The more the premium is for individuals, the more the federal tax credit.

b. Request from Secretary Costantino for a presentation on scenarios of payment and affordability: What the premiums are, what the delta is, what are different scenarios for this discussion of who pays premiums, how much the subsidy is, etc.

4. Small Employer Coverage: have to create value for small employers and that will be very difficult. Would also say that nobody has solved this problem. We are learning from the Massachusetts model and the Utah model even though both are very different. We need to know from our employers what they want out of the small business exchange. The Lt. Governor noted that this issue will need to come back to this group.

b. Jon Kingsdale - Wakely Consulting Group: One of the issues for a group like this is regarding models that need to be explored: what do you need to know? What needs to be retained to determine how best to build the exchange here in RI? Kingsdale is familiar with exchanges in Massachusetts, Utah and elsewhere, but less familiar with RI facts.

i. Key Strategic Questions: How to create a self-sustaining RI exchange? How best to serve low-income Rhode Islanders from 133-200% FPL? How do we create value for individuals? How do we create value for small employers? Therefore, we need to consider models to create value for individuals and small business employers.

ii. There are three potential options for individuals: (1) Medicaid covers up to 133% FPL. This is considered a "Robust" exchange with full functionality. (2) Medicaid covers up to 133% FPL, 133-200% FPL Basic Health Plan, and 200% + "Robust Exchange" with full functionality. (3) Medicaid covers up to 133%FPL, a basic health plan 133-200% FPL, and a "Minimalist" exchange (website only - doesn't allow for transactions, merely provides information). CK: Under the "Minimalist" exchange, could some of the functions, product definitions, and rate negotiation, be done through a regulatory function? Option 2 is the conventionally outlined option through the ACA. Question: Why would the state consider option 2? Obvious benefits to the enrollees of the basic health plan include the fact that if the state gets the numbers right, it shouldn't cost the state money. Note that each option has its challenges.

iii. Potential Exchange Models – creating values for small employers. (1) "Conventional" ACA vision: Employer chooses a tier (Platinum to Bronze Plan A - Plan C Matrix).

1. Benefits are the covered services, the actuarial value is how much of the 100% the plan will cover, and how much the individual puts in; the cost sharing formula. Plan design is where you see

different benefit design. The driving value propositions of the Exchange are making it easy for consumers. This is really not a great innovator for most small businesses, especially in RI with a small number of employers. Alternative potential models are (A) Competitive award to one insurer – select insurer with highest medical loss ratio/lowest premium, outsource enrollment, billing, collections, customer service to the winning insurer; (B) Outsource to another state or regional exchange: outsource all functionality to existing state exchange and consider developing interstate compact; or (C) Direct purchase by employers: possible "defined contribution" model. This could rely on infrastructure built to support "robust" individual exchange [noted that Utah model is close to option D].

iv. Combined Individual & Small Employer Models: So these are the five that we will dig into: are they legal? Where is the value added? Before you evaluate these, don't we need some basic goals or values that the group thinks of as important? Before we can say, #1 is better than #5, don't we need to discuss what these goals are, and what the values are? This is the work that will go on this summer, so if at the next meeting we want to lay out some guiding principles for what to assess, we can do that and discuss further in the work group – we can do this at the next meeting. We will develop criteria to evaluate these options. They will be very subjective.

III. Adjourn – The meeting adjourned at 3:40pm.